CHILD HEALTH PROFILE

Manchester Health Department
1528 Elm St.
Manchester NH 03101
Tel: (603) 624-6466 Fax: (603) 624-6584

Instructions to Parent: In order to best meet your child's educational and health needs in the school setting we need background information relating to the child's current health status. Please have your physician fill out this form and return it to the school by: _____

Child's Name | Date of Birth | Age

Parent / Guardian Name(s) | Home Address

Work Telephone number | Home Telephone number | Other contact telephone number

Instructions to Physician: The child identified above is presently registered for our school program. Information from your records regarding present physical state, response to illness and development characteristics will be very helpful in the preparation of a program that will be promotional to his/her well being.

_____
School Nurse / Community Health Nurse

HISTORY

A. Prenatal, perinatal and postnatal development: any significant findings that could influence this child's adaptation to school setting (i.e. physical handicap, sensory loss, and developmental irregularities)?

B. Any chronic illness that may require medication (e.g. recurrent ear infections, seizure disorder, allergies)? (*Medication taken during school hours, requires a written physician's order)*

C. Any hospitalizations, operations, injuries, or special test of which we should be aware? (List year)

D. Pertinent family social or health characteristics?

E. Immunizations and infectious disease history:

	Dates of Illness	Date of Immunization	Date of Boosters
Diphtheria Pertussis Tetanus			
HIB			
Polio (oral)			
DTP/HIB			
Polio (IPV)			
Measles Mumps Rubella			
Chicken Pox			
Hep B			
Influenza			
Pneumococcal			

Tests	Date	Method	Result
TB			
Vision			
Hearing			

TESTS	DATE	RESULTS
Hgb/Hct/Ep		
Urine		
Lead		
Other		

_____
Signature of Parent or Guardian

CHILD HEALTH PROFILE

HEALTH ASSESSMENT:

Date of Physical Exam: _____ Height: ____% Weight: _____% Head Cir: _____% B.P. _____

General Appearance: (Body portions, body build, etc.)

Check each line	Normal	Abnormal	Needs Follow-Up	Not Examined
Skin/Scalp				
Nutrition				
Neurological & Muscular				
Spine & Extremities				
Eyes				
Ears				
Nose, Throat, Mouth				
Teeth & Gums				
Glands (including Thyroid)				
Chests, Breasts				
Heart, Lungs				
Abdomen				
Genitalia				

TEMPERAMENT: _____ Easy-Going _____Average _____Difficult

ASSESSMENT OF DEVELOPMENT

A. Estimate of level of physical

(1)	Infancy (0-2)	_____ early	_____ mid	_____ late
(2)	Mid pre-school (2-4)	_____ early	_____ mid	_____ late
(3)	Preschool (4-6)	_____ early	_____ mid	_____ late
(4)	School age (6-10)	_____ early	_____ mid	_____ late
(5)	Adolescent	_____ early	_____ mid	_____ late

B. Estimate of functional capacity:

	Delayed for Develop. Phase	Consistent with Develop. Phase	Advanced for Develop. Phase	Comments
Gross Motor				
Fine Motor				
Communication				
Social Skills				
Emotional Behavior				

SUMMARY:

1. Are there any special medical needs to be provided in the school setting? _____ Yes ____ No

2. Specify medical needs in the school setting:

3. Are there any specific recommendations regarding family support? _____ Yes _____ No

PHYSICIAN'S SIGNATURE: _____ DATE: _____